Pogsara Yia!

(Girls First!)

FINDINGS FROM THE NAVRONGO HEALTH RESEARCH CENTRE
FEMALE GENITAL MUTILATION ERADICATION INTERVENTION

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FGM: VIOLENCE AGAINST WOMEN

Female circumcision, a broad term for traditional practices involving the cutting of female genitalia leading to the partial or the total removal of the female genitalia for non-therapeutic reasons has existed for centuries. In recent times it has become a matter for international discussion. As Fran Hosken, a prominent anti-FGM advocate states, "FGM is… a culturally approved form of violence against women…."[1] This observation has led to, among other things, prescriptions on what must be done to end the practice. FGM is associated with direct health and psychological hazards including pain, trauma, and severe physical complications, such as bleeding, infections, or even death, as well as indirect psychological effects on women's self-image and sexual lives. National FGM prevalence is estimated to range between 20-30 percent, while the combined prevalence for the Upper West and Upper East regions is about 86%. In 1995, the Navrongo Health Research Centre (NHRC) embarked on intervention research aimed at describing and understanding the practice of female circumcision in the Kassena-Nankana district (KND) with the aim of speeding up its eradication. A 1995 survey of households in the district revealed that 77% of 5,275 randomly selected women of reproductive age had undergone FGM. In 1995–1996, a clinic-based study of 398 pregnant women seeking prenatal care found that about 62% of them were circumcised between 15 and 19 years of age, and by age 20, 80% had already undergone FGM.

Couples often take actions that are dangerous to the health of their daughters

A study was conducted in order to investigate the social, cultural, and physical mechanisms that sustain female circumcision, with particular attention to clarifying gender roles in FGM decision-making. Twenty-two focus group discussions with men and women of various age groups in KND were conducted with respondents identified through a Demographic Surveillance System (DSS) database at the NHRC. On average, a focus group consisted of eight to ten participants. Briefly, results show that:

- Men and women support the notion that there are distinctly different parental roles in the sequence of decision leading to the practice of female circumcision. Typically, the mother takes primary initial responsibility for encouraging her daughter to get circumcised. The father or compound head may be asked to permit the circumcision, in which case, the father's actions are undertaken in response to decisions already taken by women.
- Circumcision is performed in the post harvest season. In the months preceding the harvest, women consult with their peers in neighboring compounds to discuss plans for circumcising girls in the community who are said to have come of age for the procedure. After a decision is reached to proceed with circumcision, girls are informed that circumcision rites will be performed. All respondents denied that any form of compulsion was employed. Instead, they stressed the view that girls are asked to decide on whether or not to undergo the procedure.
- Fathers rarely exert pressure on their daughters to be circumcised. The role of husbands is even less pronounced than the father's role.

[1] Hosken, Fran. 1993. *The Hosken Report: Genital and Sexual Mutilation of Females.* Lexington: Women's International Network News.

- Some women reported that fathers had to be consulted before the act, though in some cases, circumcision took place without the father knowing about it. Nonetheless, fathers or compound heads are asked to pay the circumcision fees for girls in their compound.
- Women view their role in fostering the circumcision of their daughters as a part of their responsibility as good mothers. Therefore, mothers try as much as possible to ensure that their daughter gets circumcised so that she will retain a respectable status among the women in the community.
- In polygamous households, tensions can arise if one woman has not circumcised her daughters while her co-wives have circumcised theirs. Therefore, when a woman arranges the circumcision of her daughter, she also eludes ridicule from the co-wives and her children. This is even more pronounced in the case of uncircumcised co-wives. A lot of pressure is put on uncircumcised co-wives to get circumcised and to avoid ridicule and any misfortune being ascribed to their not being circumcised.
- Men who opposed the practice were sometimes aware of the health implications of practicing FGM such as the effect of FGM on childbearing, but expanded this notion to include child health more generally. These views demonstrate the need to provide effective health education about the effects of FGM in ways that combat misinformation about FGM as well as provide a better understanding of why FGM should be prevented.

Discussions thus suggest that for men, the various factors that explained their support for FGM in the past have changed over time. In this light, what then can we conclude about the appropriate design of an FGM prevention programme?

- First, since the social forces that sustain FGM are complex and systemic, no one strategy or simple initiative will work. Just as FGM is sustained by a complex social system, prevention must be guided by a sophisticated sense of respect for the institutions that govern life, prevent social disorder, and sustain family values. It is particularly important to focus on the FGM motives of adults; programme oriented to adolescents alone will fail.
- Second, instituting change is possible. Social change in FGM values is already evident.
- Third, there is a need to build on the receptive audience that men represent. Chiefs, elders and other male players in the patriarchal system can be active promoters of FGM prevention. The Navrongo experiment, for example, utilizes the lineage and chieftaincy system and traditional village gatherings, known as durbars as mechanisms for communicating FGM lessons and correcting misinformation. This is a more appropriate strategy for programme success.
- Fourth, social interaction among women is dominated by exchanges in the extended family. Women who are opposed to FGM need social support for their perspective. Singing and dancing groups can be convened for the purpose of fostering FGM prevention, in order to build a programme around the strong value that women consign to group participation and collective decision-making. An effective programme of mobilizing women's extra-familial networks would offset the isolation and traditionalism that constrains the autonomy of young women.
- Fifth, the needs of unmarried and married adolescents for FGM prevention programmes cannot be separated from adolescent health needs more generally. Activities that build self-esteem and autonomy through livelihood training, peer leadership, or other adolescent outreach programme, such as sport promotions, can include FGM educational components. Building peer leadership for reproductive health is a crucial element of the Navrongo FGM eradication strategy.
- Finally, adolescent outreach activities can be designed to have a "rite of passage" component whereby young men and women receive traditional family life education and their completion of this process is acknowledged by a community celebration. In this manner, elements of social values that are so often cited as rationale for sustaining the practice of FGM can be re-associated with a programme that is designed to foster prevention of this practice.

The needs of married and unmarried adolescents go together with adolescent health needs generally

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